STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G616	A. BUILDING _____ B. WING _____	R 04/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASH CENTER INC	**3964 ABRAHAM CT LAFAYETTE, IN 47905**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This visit was for a post certification revisit to an extended recertification and state licensure survey completed on 3/13/13. This visit was in conjunction with the investigation of complaint #IN00127601. Dates of Survey: April 23, 24, 2013 Facility number: 001205 Provider number: 15G616 AIM number: 100235350 Surveyor: Amber Bloss, QIDP Wabash Center Inc. of Indiana was found to be in compliance with 42 CFR, part 483, subpart I, and 460 IAC 9 in regard to the post certification revisit to the recertification and state licensure survey. Quality Review completed 5/1/13 by Ruth Shackelford, QIDP.	{W 000}		
{W9999}	FINAL OBSERVATIONS	{W9999}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.